EyeCode Education

Afraid of Audits? You Should Be, but Not for the Reasons You Think.

Christopher Wolfe, OD, FAAO, Dipl. ABO

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Introduction

In this course we will cover:

- **Comprehensive Error Rate Testing (CERT)**
- How we can use CERT to **help guide our documentation habits**
- The difference between **fraud and abuse**
- What are **common provider mistakes** with CERT
- What **steps** should we take to prevent errors

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What is CERT?

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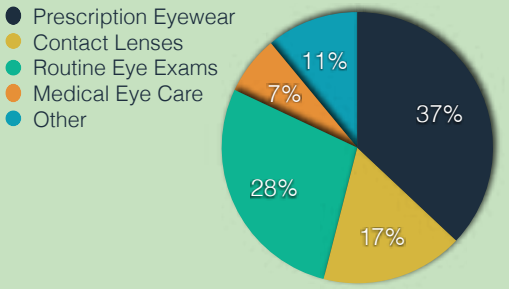
Under Manage

Average MBA Revenue Sources

Glasses and CL Sales account for **54% of revenue** for the average OD practice!

Glasses, CL Sales and Routine Eye Exams account for **82% of revenue** for the average OD practice!



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Comprehensive Error Rate Testing

History

- The Medicare FFS improper payment rate was **first measured in 1996**.
- HHS-OIG was responsible for **estimating the national Medicare FFS improper payment** rate from 1996 through 2002.
- The OIG designed its sampling method to estimate a national Medicare FFS paid claims improper payment rate only.
  - OIG's **small sample size** of approximately 6,000 claims, the OIG was unable to produce improper payment rates by contractor, contractor type, service type, or provider type.
- Following recommendations from the OIG, the **sample size was increased** when CMS began producing the Medicare FFS improper payment rate in **2003**.

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Comprehensive Error Rate Testing

Current Program

- **Measure improper payments** in the Medicare Fee-for-Service (FFS) program
- Selects a stratified random sample of approximately **50,000 claims** submitted to Part A/B MACs and DME MACs
  - Allows CMS to **calculate a national improper payment rate** and contractor- and service-specific improper payment rates.
  - Ensures a statistically valid random sample; therefore, the improper payment rate calculated from this sample is **considered to reflect all claims processed** by the Medicare FFS program during the report period.

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Current Program

Review

The sample of Medicare FFS claims is reviewed by an **independent medical review contractor** to determine if they were paid properly under Medicare coverage, coding, and billing rules.

Improper Claims

If these criteria are not met or the provider fails to submit medical records to support the claim billed, the **claim is counted as either a total or partial improper payment** and the improper payment may be recouped (for overpayments) or reimbursed (for underpayments).

Improper Payment

The last step in the process is the calculation of the **annual Medicare FFS improper payment rate**, which is published in the HHS Agency Financial Report

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Do I Have to Worry About Fraud?

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What is Fraud?

Medicare **fraud** typically includes any of the following:

- Knowingly submitting, or causing to be submitted, false claims or making misrepresentations of fact to obtain a Federal health care payment for which no entitlement would otherwise exist
- Knowingly soliciting, receiving, offering, or paying remuneration (e.g., kickbacks, bribes, or rebates) to induce or reward referrals for items or services reimbursed by Federal health care programs
- Making prohibited referrals for certain designated health

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Examples of Fraud

- Knowingly billing for services at a level of complexity higher than services actually provided or documented in the medical records
- Knowingly billing for services not furnished, supplies not provided, or both, including falsifying records to show delivery of such items
- Knowingly ordering medically unnecessary items or services for patients
- Paying for referrals of Federal health care program beneficiaries
- Billing Medicare for appointments patients fail to keep

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What is Abuse?

Abuse describes practices that may directly or indirectly result in unnecessary costs to the Medicare Program. Abuse includes any practice that does not provide patients with medically necessary services or meet professionally recognized standards of care.

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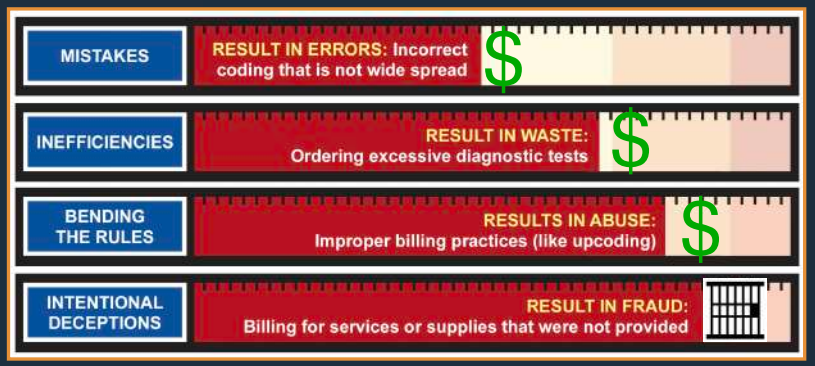
Examples of Abuse

- Billing for unnecessary medical services
- Charging excessively for services or supplies
- Misusing codes on a claim, such as upcoding or unbundling codes. Upcoding is when a provider assigns an inaccurate billing code to a medical procedure or treatment to increase reimbursement.

What is the Difference?



What does the Data Show Us?

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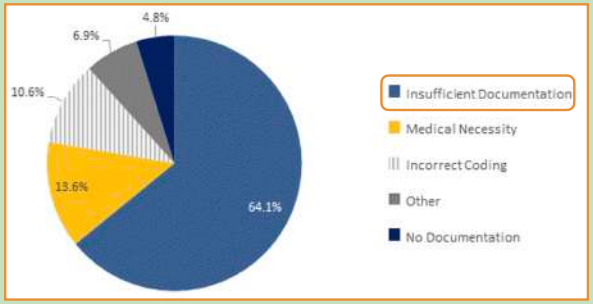
Common Causes of Improper Payment



Root Cause Description
Provider's Intent to order (for certain services) - Missing
Order - Missing
Order - Inadequate
Documentation to support medical necessity - Missing
Documentation for the associated diagnostic lab test(s) - Inadequate
Documentation for the billed date of service- Missing
Physical/Occupational/Speech Therapy - Certification/Recertification - Missing
Documentation to support the services were provided or other documentation required for payment of the code - Missing
NCD requirement(s), other documentation required for payment - Missing

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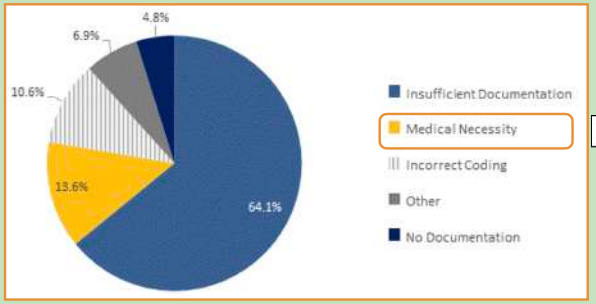
Common Causes of Improper Payment



Documentation does not support medical necessity for the service or item billed

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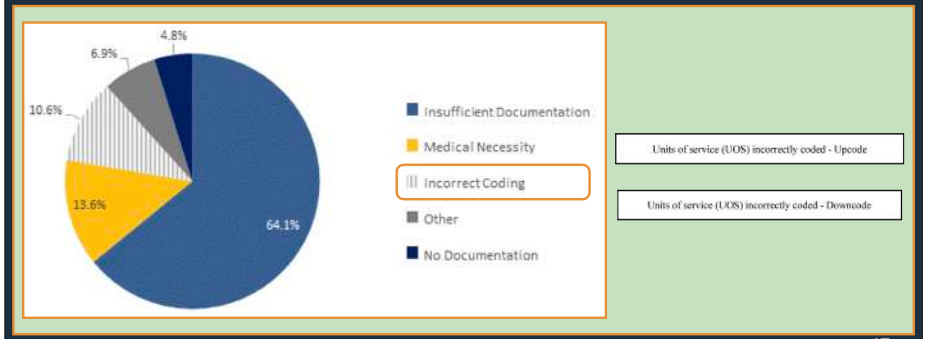
Common Causes of Improper Payment



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What is the Impact?

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How Much Does This Cost (Billions)?

Claim Type	Claims Sampled	Claims Reviewed	Total Payments	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percent of Overall Improper Payments
Part A (Total)	28,079	18,508	$291.4	$14.2	4.9%	4.3% - 5.5%	56.5%
Part A (Excluding Hospital IPPS)	8,309	7,180	$183.5	$11.6	6.3%	5.4% - 7.3%	46.3%
Part A (Hospital IPPS)	19,770	11,328	$107.9	$2.6	2.4%	2.1% - 2.7%	10.3%
Part B	14,678	14,267	$100.1	$8.5	8.5%	7.8% - 9.2%	33.9%
DMEPOS	9,646	9,235	$8.3	$2.4	28.6%	26.4% - 30.8%	9.5%
Total	**52,403**	**42,010**	**$399.8**	**$25.0**	**6.3%**	**5.8% - 6.7%**	**100.0%**

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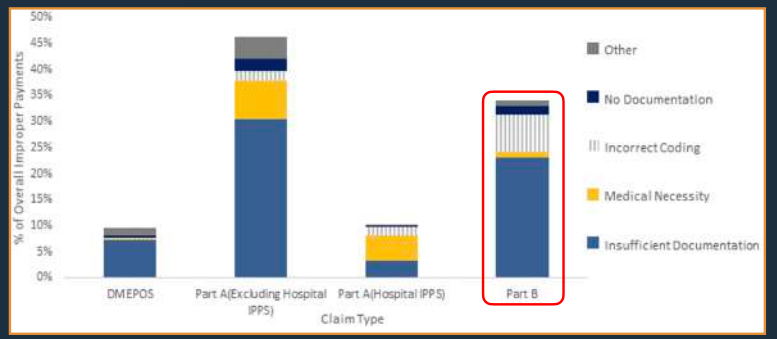
How Bad is Part B?



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What Services are Most Likely to Fail?

Part B Services (BETOS Codes)	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percentage of Service Type Improper Payments by Type of Error					Percent of Overall Improper Payments
				No Doc	Insufficient Doc	Medical Necessity	Incorrect Coding	Other	
Lab tests - other (non-Medicare fee schedule)	$817,653,571	24.8%	19.6% - 30.1%	0.7%	88.8%	8.8%	0.0%	1.6%	3.2%
Minor procedures - other (Medicare fee schedule)	$760,818,528	15.0%	9.0% - 20.9%	2.6%	90.0%	0.4%	1.8%	5.3%	3.0%
Office visits - established	$722,802,851	4.9%	3.7% - 6.1%	11.0%	38.7%	0.0%	48.5%	1.8%	2.8%
Hospital visit - subsequent	$498,391,826	9.2%	6.9% - 11.4%	8.7%	45.8%	0.0%	44.5%	1.0%	1.9%
Hospital visit - initial	$463,933,943	17.2%	14.6% - 19.8%	3.8%	24.5%	0.0%	71.1%	0.7%	1.8%
Specialist - other	$442,270,133	25.5%	17.7% - 33.2%	3.4%	92.3%	0.0%	4.4%	0.0%	1.7%
Ambulance	$405,165,149	7.9%	4.6% - 11.2%	5.4%	56.6%	31.3%	6.7%	0.0%	1.6%
Nursing home visit	$341,892,648	14.1%	11.0% - 17.2%	4.6%	37.1%	0.0%	54.9%	3.3%	1.3%
Specialist - psychiatry	$271,060,913	19.4%	12.9% - 25.8%	6.2%	87.5%	0.0%	0.7%	5.7%	1.1%
Office visits - new	$256,145,880	9.7%	6.9% - 12.4%	4.2%	6.6%	0.0%	64.0%	25.3%	1.0%

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What Can We Do?

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To Do

Document

- **Maintain accurate and complete medical records** and documentation of the services you provide.
- Ensure your **documentation supports the claims you submit** for payment.
- Good documentation practices help to ensure your patients get appropriate care and allow other providers to rely on your records for patients' medical histories.

To Do

Document

- Understand Documentation Guidelines

To Do

Document

- Ensure there is a **chief complaint** documented
- List all **addressed problems** in assessment
- **Finish** your charts
- **Sign** your charts
- **Order** tests appropriately
- **Interpret** tests

Order

- **"Order: 30-2 threshold visual field OU to evaluate for glaucomatous field loss and monitor"**
- **"Order: macular OCT OU to evaluate for macular fluid associated with wet ARMD and monitor"**

Routine screening tests that are a "standing order" for all patients as part of their preliminary tests are NOT medically necessary and should NOT be billed to the insurance company.

Interpret

1. Test **date**
2. Test **reliability** (e.g., cloudy due to cataract)
3. Test **findings** (e.g., hemorrhage)
4. **Comparison** with prior tests (when applicable)
5. **Diagnosis** (if possible)
6. **Impact** on treatment and prognosis
7. **Signature** of the physician

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Interpret

"Interpretation and report: Test 30-2 threshold visual field, shows inferior nasal step within 5° of fixation OD, no defects OS. Good reliability in each eye, appears stable based on comparison to prior testing. Continue Lumigan 0.01% and monitor in 4 months along with IOP, gonioscopy and dilated optic nerve evaluation."